| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 08/28/2014 | | |
|--|--|--|-----|---------------------|---|----------------------|----------------------------|
| | POINTE OF CARME | | | 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | • | |
| (X4) ID PREFIX TAG R000000 | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| R000117 | Survey dates: A 2014. Facility number: Provider number: AIM number: N Survey team: Sandra Nolder, F Census bed type: Residential: 31 Total: 31 Census payor typ Medicaid: 24 Other: 7 Total: 31 Sample: 8 These state finding accordance with Quality Review of Tammy Alley R1 410 IAC 16.2-5-1.4 Personnel - Deficient of the provided in the control of t | ngust 26, 27 and 28, 012309 : 012309 /A RN ne: ngs are cited in 410 IAC 16.2-5. was completed by N on September 2, 2014. 4(b) ency | ROO | 00000 | Submission of this plan of correct does not constitute admission or agreement by the provider of the truth of facts alleged or correction forth on the statement of deficiencies. This plan of correctionis prepared and submit as a requirement under state and federal law. Please accept this pla correction as our credible allegat of compliance. Please find enclosed the plan of correction for the surveyending August 28, 2014. Respectfully, Stuart Reed Administrator | n set ted n of | |
| | | ufficient in number, | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED | |
|--|--|---|-----------------|--|--------------------|
| AND TEAH | or condition | BENTH TOTAL NO. WEEK. | A. BUILDING | | 08/28/2014 |
| | | | B. WING | ADDRESS OVER STATE SID CODE | 00/20/2011 |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR | |
| CROWN | POINTE OF CARM | FI | | EL, IN 46032 | |
| | | | | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION DATE |
| TAG | | I training in accordance | TAG | DEI CHENCT) | DATE |
| | | ate laws and rules to meet | | | |
| | | 4) hour scheduled and | | | |
| | , | ds of the residents and | | | |
| | services provided | | | | |
| | | I training of staff shall | | | |
| | | equired to provide for the | | | |
| | | the residents. A minimum | | | |
| | of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents | | | | |
| | | | | | |
| | of the facility regularly receive residential | | | | |
| | _ | or administration of | | | |
| | medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred | | | | |
| | | | | | |
| | (100) residents re | | | | |
| | | g services or administration | | | |
| | | ooth, shall have at least | | | |
| | | nursing staff person | | | |
| | | y at all times for every | | | |
| | |) residents. Personnel only those duties for which | | | |
| | | perform. Employee duties | | | |
| | | written job descriptions. | | | |
| | Based on intervi | ew and record review, | R000117 | 1.No residents were harmed | 03,12,201. |
| | the facility failed | d to ensure there was | | The facility did ensure there w | |
| | adequate First A | id and CPR | | adequate CPR certified staff to cover all shifts. A First Aid | |
| | (Cardiopulmona | ry Resuscitation) | | certification class is scheduled | d for |
| | ` • | cover all shifts. This | | nursing staff. | |
| | | e had the potential to | | 2.All employee certifications | |
| | _ | esidents residing in the | | were reviewed; any nursing st | |
| | facility. | | | members without a CPR and/ First Aid certification will be | or |
| | 1401111, | | | required to attend a CPR and | |
| | Findings include | 2: | | First Aid class. Thus the facilit | у |
| | | ·- | | will ensure there is adequate | |
| | The employee re | ecords were reviewed on | | CPR and First Aid certified state to cover all shifts. | HII |
| | | A.M. The records | | 3.As a measure of ongoing | |
| | | eility had 6 out of 12 | | compliance the | |
| | mulcaled the lac | mily flad 0 Out 01 12 | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 2 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|---|-------------------------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | | B. WING | | 08/28/2014 |
| | N O T W D D = | ! | | ADDRESS, CITY, STATE, ZIP CODE | 1 |
| NAME OF F | PROVIDER OR SUPPLIER | | | TECHNOLOGY DR | |
| CROWNI | POINTE OF CARMI | EL | | EL, IN 46032 | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | regularly schedu | led employees certified | | Administrator/Directoror desig | nee |
| | in CPR and First Aid. | | | will complete an audit of the upcoming monthly | |
| | | | | schedule ongoing to ensure the | 10 |
| | The employee so | chedule as worked for | | facility has adequate CPR and | |
| | | 8/31/14 was reviewed. | | First Aid certified staff to cove | |
| | _ | licated there were no | | shifts, (please see attachment | : A). |
| | | | | 4.As a measure of quality | |
| | First Aid and CPR certified staff working for the following shifts: | | | assurance the Administrator/Director or | |
| | | | | designee will complete said | |
| | 8/17/1410 P.M6 A.M. 8/18/142 P.M10 P.M. and 10 P.M6 A.M. | | | audits monthly ongoing. Shou | ld a |
| | | | | deficient practice be noted, | |
| | | | | immediate corrective action w | |
| | | -10 P.M. and 10 P.M6 | | be taken. The plan ofcorrection | n |
| | A.M. | | | will be revised accordingly, if warranted. | |
| | | -10 P.M. and 10 P.M6 | | warranteu. | |
| | A.M. | | | | |
| | | -10 P.M. and 10 P.M6 | | | |
| | A.M. | 10 D.M. 110 D.M. (| | | |
| | | -10 P.M. and 10 P.M6 | | | |
| | A.M. | | | | |
| | | 2 P.M., 2 P.M10 P.M. | | | |
| | and 10 P.M6 A | | | | |
| | 8/24/142 P.M | -10 P.M. and 10 P.M6 | | | |
| | A.M. | | | | |
| | 8/25/142 P.M | -10 P.M. and 10 P.M6 | | | |
| | A.M. | | | | |
| | 8/26/142 P.M | -10 P.M. and 10 P.M6 | | | |
| | A.M. | | | | |
| | 8/27/142 P.M | -10 P.M. and 10 P.M6 | | | |
| | A.M. | | | | |
| | | -10 P.M. and 10 P.M6 | | | |
| | A.M. | | | | |
| | | -10 P.M. and 10 P.M6 | | | |
| | A.M. | 1 V 1 .171. WILL TO 1 .171. U | | | |
| | 8/30/1410 P.M | 6 A M | | | |
| | 0/30/1410 P.IVI | U A.IVI. | | | |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING 00 | | | COMPLETED 08/28/2014 | | |
|---|--|--|--------|--------|--|--------|------------|
| | | | B. WIN | | | 06/28/ | 2014 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| CROWN | POINTE OF CARME | EL | | | ECHNOLOGY DR EL, IN 46032 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | REGULATORY OR 8/31/1410 P.M. During an intervity P.M., the Director the schedule that current as worked indicated she was Executive Director that there was noto CPR certified state every 24 hour personnel - Nonco (f) A health screen employee of a faci contact. The screen tuberculin skin test method (5 TU, PPI positive reaction caresult shall be reconduration with the and by whom admassure the following (1) At the time of equal to the contact of the | LISC IDENTIFYING INFORMATION) 1-6 A.M. 1-7 In the service of the serv | | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | | |
| | • | ne tuberculin skin testing | | | | | |
| | | two-step method. If the | | | | | |
| | | ve, a second test should | | | | | |
| | be performed one | (1) to three (3) weeks | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 4 of 42

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | |
|-----------|--|-------------------------------|---|-------------------------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILI | NINC | 00 | COMPL | ETED |
| | | | B. WING | | | 08/28/ | 2014 |
| | | | B. WING | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ECHNOLOGY DR | | |
| CROWN | POINTE OF CARM | EL | | | EL, IN 46032 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | 1 | ID | BROWING BLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | P | REFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | rc | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | i C | DATE |
| | after the first step | . The frequency of repeat | | | | | |
| | | d on the risk of infection | | | | | |
| | with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | all maintain a health record | | | | | |
| | | that includes reports of all | | | | | |
| | | ed health screenings. | | | | | |
| | | with symptoms or signs of | | | | | |
| | | ymptoms suggestive of | | | | | |
| | | s, including, but not limited | | | | | |
| | to, cough, fever, night sweats, and weight loss) shall not be permitted to work until | | | | | | |
| | tuberculosis is rul | <u> </u> | | | | | |
| | | ew and record review, | R000 | 121 | 1.No residents were harmed | | 09/12/2014 |
| | | d to ensure a Chest X-ray | 11000 | 121 | LPN#1 had a tuberculosis risk | | 09/12/2011 |
| | l | o rule out the presence of | | assessment completed upon the | | | |
| | • | • | | | 10mm reaction to the tuberculin skin test, which indicated no symptoms of tuberculosis. LPN#1 had a CXR completed which indicated no active disease. | | |
| | | er a positive PPD | | | | | |
| | , , | or 1 of 10 employees | | | | | |
| | reviewed for PP | D tests. (LPN #1) | | | | | |
| | | | | | 2.All employee files were | | |
| | Findings include | 2: | | | reviewed to ensure all staff | | |
| | | | | | received tuberculin skin tests a | as | |
| | The employee re | ecords were reviewed on | | | required. Any positive results | | |
| | | A.M. The records | | | were audited to ensure a CXR | | |
| | | out of 5 new employees | | | was completed as well. Facility Managers will be in-serviced or | | |
| | | sts completed tested | | | the hiring process regarding | •• | |
| | | 1's date of hire was | | | tuberculin skin testing and CXI | R | |
| | _ | | | | requirements, (please see | | |
| | | had her first step PPD | | | attachment B). | | |
| | _ | n 2/27/14. The PPD | | | 3.As a measure of ongoing | | |
| | | she tested positive. The | | | compliance the | | |
| | PPD test record | indicated she was sent | | | Administrator/Director or designee will complete an aud | i+ | |
| | for a chest X-ray | y on 2/28/14. LPN #1's | | | monthly ongoing to confirm all | | |
| | employee file la | cked a Chest X-ray | | | staff received tuberculin skin to | | |
| | ^ ^ | · | | | The state of the s | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 5 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | |
|--|--|---|---|---|-------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | | B. WING | | 08/28/2014 |
| | | | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | ROVIDER OR SUPPLIER | | | TECHNOLOGY DR | |
| CROWNI | POINTE OF CARMI | ΞL | | EL, IN 46032 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE |
| | P.M., the Director indicated LPN # PPD test on 2/27 #1 was sent to a 2/28/14 to get a 6 wanted to save in to get her Chest 2 of facility). Do problems obtaining results from the 6 | iew on 8/28/14 at 2 or of Nursing (DoN) 1 did have a positive 1/14. She indicated LPN medical facility on Chest X-ray, but she noney so she attempted X-ray result from (name I indicated LPN #1 had ing her Chest X-ray other facility and she had mest X-ray until today. | | and CXR as required, (please attachment C). 4.As a measure of quality assurance the Administrator/Directoror desig will complete said audits mont ongoing. Should a deficient practice be noted, immediate corrective action will be taken. The plan ofcorrection will be revised accordingly, if warrant | nee thly |
| R000214 | each resident shall admission and shall semiannually and change in the reside often at the reside A licensed nurse sineeds of the reside Based on interviethe facility failed individual needs weight loss for 1 for evaluation of | ency of the individual needs of Il be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. shall evaluate the nursing ent. ew and record review, I to evaluate the related to a significant of 6 residents reviewed findividual needs ntial changes in a sample # 102) | R000214 | 1.Resident #102 was affected. The physician and responsible party were notified of the weig changes and orders were followed. 2.All residents with weight changes have the potential to affected. All nurses and QMA will be in-serviced on weight monitoring (at a minimum upo admission and semi-annually thereafter-unless the resident | be 's n |

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| Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. TAG Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic registered dietitian notification, (please see attachment D). 3.As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MU | JLTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|--|--|--|--|---------|------------|--|---|------------|
| NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 ID PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE desires/agrees to more frequent monitoring) and use of 24 hour report sheets as well as physician, responsible party and registered dietitian notification, (please see attachment D). 3.As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BIIII | DING | 00 | COMPL | ETED |
| NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 ID PROVIDERS PLANOF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE DEFICIENCY DATE | | | | | | | 08/28/ | 2014 |
| TAG Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. 11610 TECHNOLOGY DR CARMEL, IN 46032 ID PROVIDERS PLAN OF CORRECTION (ACCID CORRECTION PREFIX) (PACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG 12 PROVIDERS PLAN OF CORRECTION (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 13 PREFIX (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 14 PREFIX (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 15 PREFIX (PACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETICION (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETI | | | <u> </u> | D. WIN | | ADDRESS CITY STATE ZIP CODE | | |
| CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. CARMEL, IN 46032 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETIC DATE Deficiency A desires/agrees to more frequent monitoring) and use of 24 hour report sheets as well as physician, responsible party and registered dietitian notification, (please see attachment D). 3. As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the | NAME OF I | PROVIDER OR SUPPLIEF | R | | | | | |
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| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETIC DEFICIENCY) DATE COMPLETIC DEFICENCY) COMPLETIC DEFICENCY) DATE COMPLETIC DEFICENCY) COMPLETIC DEFICENCY) COMPLETIC DEFICENCY) COMPLETIC DEFICENCY | CROWN | FOINTE OF CARIN | <u> </u> | | CARIVIL | L, IN 40032 | | |
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| Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. TAG desires/agrees to more frequent monitoring) and use of 24 hour report sheets as well as physician, responsible party and registered dietitian notification, (please see attachment D). 3.As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the | PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | TE | COMPLETION |
| Resident #102's record was reviewed on 8/26/14 at 3:46 P.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pneumonia, chronic pain, anemia, depression, gastroesophageal reflux disease and osteoarthritis. monitoring) and use of 24 hour report sheets as well as physician, responsible party and registered dietitian notification, (please see attachment D). 3.As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the | TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| The "Vital Sign & Weight Flow Sheet" record had documentation of monthly weights as follows: January 2014141 February 2014140 March 2014133 April 2014130 May 2014132 June 2014134 July 2014134 July 2014137 An "Interdisciplinary Progress Note" dated 3/31/14 at 4 P.M., indicated "Weight loss noted, MD + [and] family notified, possibly D/t [due to] hx [history] of edema Continue to monitor weights monthly Res [resident] continues to eat well." The "Vital Sign & Weight Flow Sheet" record had documentation of monthly an early and registered dietician are notified as indicated, and the Service Plan/Evaluation of Individual Resident Needs is updated with any substantial changes in the resident's condition, as the rule requires weight taken on admission and semi-annually thereafter (please see attachment Ep. 4. As a means of quality assurance the DON or designee will complete the above described monitoring monthly ongoing. Should a deficient practice be observed, immediate corrective action will be taken. Additionally, the Administrator/Director or designee will monitor and sign off on the audit tool monthly ongoing. The plan of correction will be revised accordingly, if warranted. | | Resident #102's 8/26/14 at 3:46 If included, but we obstructive pulm pneumonia, chrodepression, gasted disease and osted. The "Vital Sign record had docume weights as follow January 20141. February 20141. April 2014130 May 2014132 June 2014134 July 2014133 August 201412. An "Interdisciplidated 3/31/14 at "Weight loss not notified, possibly [history] of eden weights monthly to eat well." An evaluation of loss over the last determine indivisitions was | record was reviewed on P.M. Diagnoses ere not limited to, chronic nonary disease, onic pain, anemia, roesophageal reflux oarthritis. & Weight Flow Sheet" mentation of monthly ws: 41 140 3 inary Progress Note" 4 P.M., indicated ted, MD + [and] family y D/t [due to] hx na Continue to monitor Res [resident] continues f the resident's weight to seven months, to idual needs related to the not found in the | | | monitoring) and use of 24 hour report sheets as well as physician, responsible party ar registered dietitian notification, (please see attachment D). 3. As a measure of ongoing compliance the DON will complete an audit tool monthly ongoing to ensure weights obtained are reviewed, the physician, responsible party ar registered dietician are notified indicated, and the Service Plan/Evaluation of Individual Resident Needs is updated with any substantial changes in the resident's condition, as the rule requires weight taken on admission and semi-annually thereafter (please see attachmet). 4. As a means of quality assurance the DON or designed will complete the above descrimonitoring monthly ongoing. Should a deficient practice be observed, immediate correctivaction will be taken. Additionat the Administrator/Director or designee will monitor and sign on the audit tool monthly ongo. | r nd , / nd d as th e e nent ee bed e illy, off ing. | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 7 of 42

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | | li i | IE SURVEY | |
|--|--|---|--------------|---|------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBEK: | A. BUILDING | 00 | • | 1PLETED 28/2014 |
| | | | B. WING | | | 20/20 14 |
| NAME OF | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CO | ODE | |
| CROWN | POINTE OF CARM | FI | | FECHNOLOGY DR EL, IN 46032 | | |
| | 1 | | | , 10002 | | (V5) |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH | IOULD BE | (X5) COMPLETION |
| TAG | * | R LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE A DEFICIENCY) | PPROPRIATE | DATE |
| TAG | A "Level of Sera Assessment/Eval Items" dated 1/3 indicated the reschew and swalled difficulty" An Admit Nutricated 10/1/13, we record and indicated regular diet. Sincalcium supplem vitamin D3 and Dietician (RD) is recommendation her. No further RD in resident's record regarding the rescretagarding an interval. M., the Nurse weights were seen and she should be resident regarding the resident regardi | vice sluation-Full List of 11/14 and 7/7/14, sident "Can feed self, ow foods without tional Progress Note vas found in the resident's sated the resident was on the received multivitamin, ment, iron supplement, Lasix. The Registered indicated there were no this and she would follow notes were found in the l. Further information sident's weight loss was the Executive Director of Nursing (DoN) and the (NC) during the Daily | TAG | DEFICIENCY) | | DATE |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 8 of 42

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | 00 | COMPLETED 08/28/2014 | |
|---|--|---|---------------------|---|----------------------|
| | ROVIDER OR SUPPLIER | | STREET 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | the resident's ind re-evaluated regasignificant weight. A current policy OF INDIVIDUA undated, provide Director on 8/27/indicated "Policy be updated quarte assessments will resident's request known substantia resident's conditional address the resident's indicated the resident's conditional tresident's conditional tr | titled "EVALUATION L RESIDENT NEEDS" d by the Executive /14 at 9:45 A.M., /Said assessments will erly. More frequent be performed upon the t or at the time of a all change in the on. Assessments will ent's physical/mental ence with activities of | | | |
| R000217 | the facility, using a members, shall ide services to be prov follows: | ency pletion of an evaluation, appropriately trained staff entify and document the vided by the facility, as | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 9 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE | SURVEY |
|--|--|-------------------------------|---------|------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A RIII | LDING | 00 | COMPL | ETED |
| | | | B. WIN | | | 08/28/ | /2014 |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | TECHNOLOGY DR | | |
| CDOWN | POINTE OF CARM | El | | | EL, IN 46032 | | |
| CROWN | FOINTE OF CARW | <u></u> | | CARIVIE | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | (D) preference; | | | | | | |
| | of the resident. | effered about he was invested | | | | | |
| | (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires | | | | | | |
| | | | | | | | |
| | | e facility or the resident | | | | | |
| | may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | no need for a change in services. (5) If administration of medications or the | | | | | | |
| | | | | | | | |
| | | ential nursing services, or | | | | | |
| | both, is needed, a | licensed nurse shall be | | | | | |
| | | cation and documentation | | | | | |
| | of the services to | - | | | | _ | |
| | Based on intervi | ew and record review, | R00 | 00217 | 1.Resident #102 was affecte | | 09/12/2014 |
| | the facility failed | d to update a resident's | | | The physician and responsible party were notified of the weig | | |
| | service plan rela | ted to a significant | | | changes and orders were | 111 | |
| | weight loss for 1 | of 6 residents reviewed | | | followed. | | |
| | _ | vice plans for substantial | | | 2.All residents with weight | | |
| | 1 0 | nple of 6. (Resident # | | | changes have the potential to | | |
| | 102) | ipie of o. (resident " | | | affected. All nurses and QMA | 's | |
| | 102) | | | | will be in-serviced on weight | | |
| | T: 1: : 1 1 | | | | monitoring (a minimum of on | | |
| | Findings include |) : | | | admission and semi-annually a per rule unless more frequent | | |
| | | | | | monitoring agreed to and/or | | |
| | Resident #102's | record was reviewed on | | | desired by the resident) and u | se | |
| | 8/26/14 at 3:46 l | P.M. Diagnoses | | | of 24 hour report sheets as we | | |
| | included, but we | ere not limited to, chronic | | | as physician, responsible part | y | |
| | obstructive puln | nonary disease, | | | and registered dietitian | | |
| | - | onic pain, anemia, | | | notification, (please see | | |
| | _ | roesophageal reflux | | | attachment D). | | |
| | disease and oste | | | | 3.As a measure of ongoing compliance the DON will | | |
| | uisease and oste | oarmins. | | | complete an audit tool monthly | v of | |
| | | | | | | , 51 | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 10 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SU | JRVEY |
|--|---|------------------------------|------------------|------------|---|--------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIJI | DDIC | 00 | COMPLET | ΓED |
| | | | A. BUI B. WIN | LDING | | 08/28/2 | 014 |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | 1 | TECHNOLOGY DR | | |
| CDOWN | POINTE OF CARM | El | | | EL, IN 46032 | | |
| CROWN | POINTE OF CARIVI | CL . | | CARIVIE | EL, IN 40032 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE (| COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | The "Vital Sign | & Weight Flow Sheet" | | | applicable weights obtained | | |
| | record had docu | mentation of monthly | | | and ongoing to ensure weights | 8 | |
| | weights as follows: | | | | obtained are reviewed, the | ad | |
| | January 20141 | | | | physician, responsible party au registered dietician are notified | | |
| | February 2014 | | | | indicated, and the Service | 1 43 | |
| | 1 | | | | Plan/Evaluation of Individual | | |
| | March 2014133 April 2014130 May 2014132 June 2014134 July 2014133 | | | | Resident Needs is updated with | th | |
| | | | | | any substantial changes in the | | |
| | | | | | resident's condition, (please so | ee | |
| | | | | | attachment E). | | |
| | | | | | 4.As a means of quality assurance the DON or designed | 20 | |
| | August 201412 | 27 | | | will complete the above descri | | |
| | | | | | monitoring monthly ongoing. | bea | |
| | An "Interdisciplinary Progress Note" | | | | Should a deficient practice be | | |
| | _ | 4 P.M., indicated | | | observed, immediate correctiv | e | |
| | | ted, MD + [and] family | | | action will be taken. Additiona | ılly, | |
| | _ | | | | the Administrator/Director | | |
| | | y D/t [due to] hx | | | ordesignee will monitor and sign | gn | |
| | _ · · · · | na Continue to monitor | | | off on the audit tool monthly | | |
| | | Res [resident] continues | | | ongoing. The plan of correction will be revised accordingly, if | | |
| | to eat well." | | | | warranted. | | |
| | | | | | warrantea. | | |
| | The resident's re | cord lacked an updated | | | | | |
| | | a significant weight loss | | | | | |
| | | om February 2014 to | | | | | |
| | | • | | | | | |
| | | h a continued weight loss | | | | | |
| | into August 201 | 4. | | | | | |
| | | | | | | | |
| | An "EVALUAT | | | | | | |
| | NEEDS/SERVI | CE PLAN" dated 1/31/14 | | | | | |
| | and 7/7/14, indic | cated "Feeding or Eating: | | | | | |
| | • | elf meals and snacks: | | | | | |
| | _ | dently feed self. Both | | | | | |
| | Service Plan doo | 2 | | | | | |
| | | | | | | | |
| | _ | ording the resident's | | | | | |
| | significant weigh | ht loss from February | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 11 of 42

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | NSTRUCTION 00 | (X3) DATE COMPI 08/28 | |
|--------------------------|--|---|--|---|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 11610 7 | DDRESS, CITY, STATE, ZIP COL ECHNOLOGY DR EL, IN 46032 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| | 2014 to March 2 weight loss into | 014 and her continued August 2014. | | | | |
| | dated 10/1/13, w record and indica a regular diet. Sh calcium supplem vitamin D3 and in Dietician (RD) in | rional Progress Note ras found in the resident's rated the resident was on ne received multivitamin, nent, iron supplement, Lasix. The Registered indicated there were no resident would follow | | | | |
| | resident's record regarding the res requested from t (ED), Director o | otes were found in the . Further information sident's weight loss was he Executive Director f Nursing (DoN) and at (NC) during the Daily /26/14. | | | | |
| | A.M., the Nurse weights were set and she should he resident regarding 140 to 133 poun was a significant indicated the Phythere was no new the Service Plan | consultant indicated the at to the RD every month have been looking at the ag the weight loss from ds in a month, since it tweight loss. She sysician was notified and worders. She indicated was not updated sident's significant weight | | | | |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COMF - 08/28 | E SURVEY LETED 3/2014 |
|--------------------------|---|--|--|--|-----------------|-----------------------------|
| CROWN | PROVIDER OR SUPPLIER | | 11610 Т | ADDRESS, CITY, STATE, ZIP CO FECHNOLOGY DR FL, IN 46032 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | P.M., the Director she used the Eva Plan and the Leva Assessment/Eva Plan for the residual A current policy OF INDIVIDUA undated, provide Director on 8/27 indicated "Policy be updated quart assessments will resident's reques known substantivesident's conditional address the residually living and completion of arthe facility, using trained staff, sha the services provide as follows. Procoffered to the incappropriate to the | luation as the Service dents. titled "EVALUATION AL RESIDENT NEEDS" ed by the Executive /14 at 9:45 A.M., ySaid assessments will early. More frequent be performed upon the t or at the time of a all change in the ion. Assessments will ent's physical/mental ence with activities of | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 13 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 | | | |
|--|---|--|--|--|----------------------|--|
| (X4) ID PREFIX TAG | SUMMARY S (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| R000241 | the provision of rebe as ordered by and shall be supe on the premises of (1) Medication shalicensed nursing predication aides. Based on observed record review, the medication was apartment for 1 or reviewed for me resident's apartment. Findings included During a resident 11:03 A.M., Resto pick up a white and set it back defront of her next Styrofoam cup, soufflé cup, som | Offense ation of medications and sidential nursing care shall the resident's physician rvised by a licensed nurse of on call as follows: all be administered by personnel or qualified ation, interview and the facility failed to ensure not left in a resident's being dications left in a ment. (Resident #413) | R000241 | 1.Resident #413 was not harmed. Immediately upon notification the QMA returned the resident room and noted the resident did not feel like taking her medications. The medications were then removand disposed of. The physicia and responsible party for the resident were notified. The Q was immediately re-educated the facility's medication administration policy. 2.All residents requiring medications to be administere by staff have the potential to be affected. All nurses and QMA' were re-educated on the facility policy on Medication Administration. The DON or designee has completed medication administration | hat ed n MA on | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 14 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|--|--|-----------|---------|---|---------------------|-----------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | 00 | COMPLETE | ED |
| | | | B. WING | 1,0 | | 08/28/201 | 14 |
| | | | | TREET A | DDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | ECHNOLOGY DR | | |
| CROWN | POINTE OF CARMI | EL | | | L, IN 46032 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES |] | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PR | EFIX | (EACH CORRECTIVE ACTION SHOULD BE | TE CO | OMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | 7 | ΓAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | DATE |
| ing | not taken her morprobably had bet resident at that ti cup, looked in it footstool. She in "The girl brough this morning, but them yet because bothering me, so later." The reside footstool. She in brought me a glapills with." On 8/27/14 at 11 soufflé cup was it. The cup contawhite pill, a blue other white pills | orning pills yet, but she ter take them. The me picked up the soufflé and set it down on the adicated at that time, t me my pills about 8 t I didn't feel like taking e old Arthur was I put them here to take ent pointed to her adicated, "She even ass of water to take my 1.03 A.M., a white observed with 10 pills in ained a large oval shaped in pill, a red pill and 7 in the soufflé cup setting | | | observations on all nurses and QMA's with satisfactory performance noted. 3.As a measure for ongoing compliance the DON or design will complete medication administration observations at varied times on varied shifts, (attachment F) weekly for four weeks, then every two weeks four weeks, then monthly ongoing. 4.As a measure of quality assurance the DON or design will complete the above descrimonitoring ongoing. Should a deficient practice be observed immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator/Directoror design will monitor and sign off on the monitoring tools on a monthly | see for ee bed , II | |
| | next to the glass Styrofoam cup. | of water in the | | | basis ongoing. | | |
| | During an interv A.M., QMA (Qu #2 indicated she her morning med approximately 8 watched her place to her mouth, the residents inhaler resident must no | 230 A.M., and she had the the medication cup up ten she went to get the s. QMA #2 indicated the | | | | | |

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | A. BUILDING 00 COMPLETED 08/28/201 | | |
|---|---|--|------------------------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | | 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | observed to know and the resident I apartment. QMA medications off to indicated at that the were the resident At that time the rown was going to take QMA #2 instruct late to take the rown was observed platthe sharps box on At that time QMA resident had gotto bathroom and medications. Sho observed her take Resident #413's 18/27/14 at 12:32 included, but we cerebrovascular affibrillation, diabethypertension, convascular dementions osteoarthritis. A (MAR) Medic Record dated Au | A #2 obtained the cup of the footstool and time these medications. Its morning medications are sident indicated she the medications and the test the medications and sted the resident it was to redications and she to retonight. QMA #2 to the medication in the medication cart. A #2 indicated the ten up to go to the cust not have taken her test indicated she had not the medications. The record was reviewed on P.M. Diagnoses | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 16 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | LDING | NSTRUCTION 00 | (X3) DATE COMPL 08/28/ | ETED | |
|--|--|--|---------------------|---|------|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET A 11610 T | DDRESS, CITY, STATE, ZIP CODE ECHNOLOGY DR L, IN 46032 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| IAU | 7/18/14Burpop release) (An Anti 150 mg (milligra mouth daily for 67/18/14Digoxin medication used 250 mcg (microg mouth daily for 67/18/14Diltiaze release) (An Antimg give one table diagnosis atrial from 7/18/14Claritin medication) 10 mouth daily for 67/18/14Multivit medication) give daily for diagnosis of dep 7/18/14Sertrali (An Antidepress give one tablet be diagnosis of dep 7/18/14Metform medication) 500 mouth two times diabetes mellitus 7/18/14Potassi (An electrolyte segon 20 meq (milliequest 20 meq (milliequest 20 meq (milliequest 20 meq (milliequest 21/18/14Acetam 7/18/14Acetam 7/18/14Ace | ion SR (sustained idepressant medication) ams) take one tablet by diagnosis of depression. In (An Inotropic to treat atrial fibrillation) grams) take one tablet by diagnosis of atrial if heart rate below 60. If heart rate below 60. If heart rate below 60 is mouth daily for ibrillation. If (An Antihistamine in give one tablet by diagnosis of allergies. Itamin (A supplement is of supplement. In the HCL (Hydrochloride) ant medication) 50 mg y mouth daily for ression / anxiety. In the Hypoglycemic is give one tablet by daily for diagnosis | IAU | | | DATE |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| | | (X2) MULTIPLE CO | | li i | TE SURVEY | |
|-----------|--|--------------------------------|-------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | | IPLETED |
| | | | B. WING | | <u> </u> | 28/2014 |
| NAME OF F | PROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP CO | ODE | |
| | | | | TECHNOLOGY DR | | |
| CROWN | POINTE OF CARM | EL | CARME | EL, IN 46032 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORE | RECTION | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A | IOULD BE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | | DATE |
| | • | (650 mg) by mouth every | | | | |
| | six hours as need | • | | | | |
| | | ations to be administered | | | | |
| | and observed an | d to be taken, by staff. | | | | |
| | A document title | ed "PRN Medication | | | | |
| | | icated on 8/27/14 at 9 | | | | |
| | | nt was given Tylenol | | | | |
| | · · | n) 325 mg times 2 tablets | | | | |
| | (650 mg) by QMA #2 for a pain level of 7 on a pain level of 0 to 10. The medication was effective for pain relief at | | | | | |
| | | | | | | |
| | | | | | | |
| | | ne that the medication | | | | |
| | | on this form had a line | | | | |
| | | | | | | |
| | that indicated "E | t with a message written | | | | |
| | mai maicated "E | ZKKUK. | | | | |
| | An "EVALUAT | TION OF | | | | |
| | NEEDS/SERVI | CE PLAN" dated | | | | |
| | 7/18/14, indicate | ed in the Management of | | | | |
| | Oral Medication | s section that the resident | | | | |
| | was unable to ta | ke medications unless | | | | |
| | administered by | someone else. | | | | |
| | | | | | | |
| | A "Level of Serv | | | | | |
| | Assessment/Eva | luation" dated 7/17/14, | | | | |
| | indicated for the | judgment section that | | | | |
| | the resident mar | ked poor decisions and | | | | |
| | required cueing | and supervision in | | | | |
| | planning, organi | zing and correcting her | | | | |
| | daily routines. | The memory section | | | | |
| | | quired cueing less than | | | | |
| | | seven day period. The | | | | |
| | | cedures section indicated | | | | |
| | 1 | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 18 of 42

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING O COMPLETED 08/28/2014 | | | |
|---|--|--|--------------------|---|------|
| | ROVIDER OR SUPPLIER | EL. | 11610 ⁻ | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| | SUMMARY ST (EACH DEFICIENCE REGULATORY OR the resident had to administered by or medication administered judgments and/or effect. During an interviolation of the second of the se | catement of deficiencies cy must be preceded by full LSC IDENTIFYING INFORMATION) to have her medications caregivers and/or mistration observed that at for necessity, dosage ew on 8/27/14 at 11:25 Consultant (NC) and the for (ED) indicated QMA bserved Resident #413 ons. The ED indicated short term memory titled "Medication undated, provided by the 19:30 A.M., indicated facility shall receive redered by their physician medical conditionsIf administer medications eminders, a licensed I medication aide shall liminister medications as mysicianAlso, the oncur, in the form of a my that the resident may medication(s). If the | STREET A | TECHNOLOGY DR | (X5) |
| | independent adm medication (s), n | inistration of the nedication administration by a licensed nurse or a | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 19 of 42

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING 00 COMPLETED 08/28/2014 | | | | | |
|---|---|---|--|---|----------------------|--|--|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| R000273 | (f) All food prepara (excluding areas in maintained in acco- local sanitation and standards, includin Based on observa- record review, the dispose of expire cans and properly 1 of 1 kitchen of practice had the p | al Services - Deficiency ution and serving areas residents ' units) are ordance with state and d safe food handling ag 410 IAC 7-24. ation, interview and e facility failed to d food items and dented y cover prepped food for oservations. This deficit potential to affect 31 of oneing served food from | R000273 | 1.All expired foods and dent cans were immediately dispos of. The sandwiches were wrapped in plastic wrap. No residents were harmed. 2.All residents have the potential to be affected. The kitchen was checked to ensure was free from expired foods, dented cans, and foods not covered appropriately. All kitch staff will be in-serviced on Receiving Procedures for Foo | e it | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 20 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|--|--|--|------------------|---------|--|------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | л ріп | ILDING | 00 | COMPLETED |
| | | | A. BUI B. WIN | | | 08/28/2014 |
| | | | D. WII | | ADDRESS, CITY, STATE, ZIP CODE | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | | |
| CDOMAN | | = 1 | | | ECHNOLOGY DR | |
| CROWN | POINTE OF CARMI | <u> </u> | | CARIVIE | EL, IN 46032 | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE |
| TAG | The kitchen tour 8/26/14 at 10 A.1 Manager in atten 1. The reach-in have the followin A medium sized Salad" with a use a date marked or marker that indic A medium sized Salad" with a use a date marked or marker that indic A large containe Dressing" with a and a date marker that indic A large containe Dressing" with a and a date marker that indic A large containe Dressing" with a and a date marker that indic A gallon contain use by date of 6/0 on the lid with a indicated 6/17/14 | was completed on M., with the Kitchen idance. cooler was observed to ing items: container labeled "Fresh is by date of 8/14/14 and in the lid with a black cated 7/23/14. container labeled "Fresh is by date of 8/20/14 and in the lid with a black cated 7/23/14. r of "Homestyle Ranch is use by date of 6/13/14 is don the lid with a black cated 7/16/14. r of "Homestyle Ranch is use by date of 6/13/14 is don the lid with a black cated 7/16/14. r of "Homestyle Ranch is use by date of 6/13/14 is don the lid with a black cated 7/10/14. er of "Mustard" with a black cated 7/10/14. | | TAG | and Non Food items and Stora of Leftovers, (please see attachment G). 3. As a measure for ongoing compliance the Dietary Managor designee will complete an aweekly ongoing to ensure food are stored and disposed of appropriately, (please see attachment H). 4. As a measure of quality assurance the Dietary managor designee will complete said monitoring weekly ongoing. Should a deficient practice be observed, immediate correctivaction will be taken. The plan ofcorrection will be revised accordingly, if warranted. The Administrator/Director or designee will monitor and sign on the monitoring tools on a monthly basis ongoing. | age ger audit ds |
| | _ | Theese sandwiches that brown colored paper | | | | |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | 00 | COMPLETED 08/28/2014 | |
|---|---|--|---------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | | 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | the sandwiches. labeled as "Turke sandwiches for to 8/26/14." The sit observed to be ut sandwiches were the brown paper. 2. A reach-in free have a pie labele label indicated it and was to be used. 3. The storage at the following der 106 oz. (ounces) 106 oz. Mandarit 6 lbs. (pounds) 1 6 lbs. (pounds) 1 6 lbs. 9 oz. Dicector 7 lbs. Apple filling. During an intervix Kitchen Manager Salad" was Chief the Chicken Salad Mustard and Quidisposed of. She made the Quiche in the reach-in fron Chef had made the morning and she them in plastic were said to be used. | bonight's dinner and dated des of the tray were incovered and the esticking out from under dezer was observed to das a "Quiche" and the was prepared on 7/15/14 ed by 7/21/14. There are was observed to have inted cans on the shelves: Diced Peaches in Oranges O oz. Salsa De Queso I Pears | | | |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING B. WING | 00 | COMPLETED 08/28/2014 | |
|---|---|--|--------------|---|------|
| | ROVIDER OR SUPPLIER | | 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| | SUMMARY ST (EACH DEFICIENCE REGULATORY OR dented cans for control delivered, but if so that to dispose of the dated 11/12/2008 Executive Direct 9:30 A.M. The policy indicated and non-food item upon receipt prior delivery personn issued by the approximation delivery personn issued by the approximation of the following items: quality. Any item the following items: quality. Any item the following share Excessive dented a current policy Leftovers" dated provided by the I A.M. The policy the policy of this be stored according an itation standary lace leftovers in with tight-fitting | EL TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Tredit when the cans were she was unable then she If the dented cans. Titled "Receiving Tood & Non Food Items" Is, was provided by the Tor (ED) on 8/28/14 at The ated, "Policy: All food The ated, "Policy: All food The ated of the the comprise of the comprise vendor if The ated of the the comprise of the compri | STREET 11610 | TECHNOLOGY DR | (X5) |
| | Cooked food pro discarded after th | ducts should be | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 23 of 42

| NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES | | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 | | | | ETED | |
|---|--|--|-------|--------------------|---|---------------------------------------|----------------------------|
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PF | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | (X5) COMPLETION DATE |
| R000297 | (c) If the facility co administers medic facility shall do the (1) Make arranger pharmaceutical seprovide residents medications in acclaws of Indiana. Based on interviethe facility failed medications were Pharmacy for 2 comedications were availability from (Resident #102 at Findings include 1. The record for reviewed on 8/20 Diagnoses include to, chronic pain, chronic obstruction and peripheral are A (MAR) Medic Record dated Auwere not limited Physician orders 5/21/14Morphi Release) (An opinion of the content of the facility shall be administed to the facility s | ervices - Noncompliance introls, handles, and ations for a resident, the efollowing for that resident: ments to ensure that ervices are available to with prescribed cordance with applicable ew and record review, at to ensure that envices are available from the environment of 8 residents whose enviewed for the Pharmacy. End #413) The Resident #102 was 6/14 at 3:46 P.M. Eled, but were not limited environment of the environment o | R0002 | 297 | 1.Resident #102 and #413 work harmed. The physician and responsible party were notified resident #102 and #413. Resident #102 and #413. Resident #102's prescription of Morphine Sulfate was filled promptly when the hard script was received by the pharmacy per D.E.A. guidelines. Resider #413 received medications uppreceipt from the pharmacy. The pharmacy and facility worked with the physician to obtain the pricauthorization for the Brovana solution. 2.All residents utilizing medications have the potential be affected. All medication can were checked with the medical administration records to ensurall ordered medications were present. All nurses and QMA's were re-educated on the procedure for medications unavailable for administration, (please see attachment, D). 3.As a measure for ongoing compliance the DON or design will review MAR's weekly ongoto monitor for medication | d d d d d d d d d d d d d d d d d d d | 09/12/2014 |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 24 of 42

| | NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---------------------------------|--|--|
| | | B. WING | | 08/28/2014 |
| | PROVIDER OR SUPPLIER IPOINTE OF CARMEL | 11610 ⁻ | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | one tablet by mouth every 12 hours for diagnosis chronic pain. 8/27/14Hold Morphine sulfate ER 100 mg until it arrives from the Pharmacy. The MAR dated August 2014, indicated that from 8/23/14 at 8 P.M. to 8/27/14 at 8 A.M., all the nurses and QMA's (Qualified Medication Aides) initials were circled on the 8 A.M. and 8 P.M. boxes for the the Morphine Sulfate order for a total of 10 doses of Morphine Sulfate not administered. The back of the MAR dated August 2014, indicated: 8/24/14 at 9 A.M., "Morphine Sulf ER 100 mg not available." 8/25/14 at 9 A.M., "morphine Sulf ER 100 mg not available pharmacy notified." 8/26/14 at 9 P.M., Morphine sulf ER 100 mg supply MD & pharmacy notified." 8/26/14 "Morphine Sulf 100 mg supply Exhausted pharmacy notified." 8/27/14 "Morphine Sulf 100 mg supply Exhausted pharmacy notified." An "Interdisciplinary Progress Note" dated 8/18/14 at 9 P.M., indicated "MD faxed for new Rx [prescription] for Norco [Hydrocodone]" An "Interdisciplinary Progress Note" | | unavailability, please see attachment I). Any medication noted to be unavailable will be addressed immediately to ensithe resident receives medicat in a timely manner In order to prevent a disruption of their diregimen. 4. As a measure of quality assurance the DON will compite above described monitoring ongoing. Should a deficient practice beobserved, immedia corrective action will be taken. The plan of correctionwill be revised accordingly, if warrant. The Administrator/Director ordesignee will monitor and soff on the monitoring tools on monthly basis ongoing. | e sure sure lions lette lang lette late late late late late late lat |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING B. WING | 00 | COMPLETED 08/28/2014 |
|--------------------------|---|--|---------------------|---|-----------------------|
| | PROVIDER OR SUPPLIER | EL. | 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| IAU | dated 8/25/14 at "Resident is out of Resident needs in notified, MD not Family notified, MD not Family notified, An "Interdiscipli dated 8/26/14 at "Resident out of pharmacy awaiting before they can see [complaints of] padministered" A "Consolidated the Pharmacy day indicated 60 Morning tablets were a from the Pharmacy day indicated the medication with the medication with the pharmacy. See would communicated the medication with the Pharmacy. See would communicated the medication with the Pharmacy in | 8 A.M., indicated of Morphine as of day 3. ew script, pharmacy ified, D.O. N. notified, Resident notified." nary Progress Note" 9 P.M., indicated Morphine MD aware ng script hard copy end per pharmacyc/o pain scheduled Norco Delivery Sheet" from ted 8/27/14 at 8:30 P.M., rphine Sulfate ER 100 accepted by LPN #3 cy delivery personnel. Sew on 8/28/14 at 10:17 Consultant indicated a pon on the MAR indicated as not given. She dent's Morphine Sulfate delivered until 8/27/14 macy needed a hard | | | |
| | | to them. She indicated | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 26 of 42

| | OF CORRECTION IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING | 00 | i í | E SURVEY PLETED |
|--------------------------|--|---------------------------------|--|---------|----------------------------|
| | | B. WING | | - 08/2 | 8/2014 |
| | PROVIDER OR SUPPLIER | 11610 7 | DDRESS, CITY, STATE, ZIP CO ECHNOLOGY DR EL, IN 46032 | DE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| | someone from the facility communicated to the Physician he needed to write a hard script and leave it at the facility and the facility would place it in the tote to send to the Pharmacy. | | | | |
| | 2. The record for Resident #413 was reviewed on 8/27/14 at 12:32 P.M. Diagnoses included, but were not limited to, cerebrovascular accident, chronic atrial fibrillation, diabetes mellitus type II, hypertension, congestive heart failure, vascular dementia, depression, and osteoarthritis. | | | | |
| | A (MAR) Medication Administration Record dated July 2014, included, but were not limited the following Physician orders: 7/18/14Multivitamin (A supplement medication) give one tablet by mouth daily for diagnosis of supplement. 7/18/14Sertraline HCL (Hydrochloride) (An Antidepressant medication) 50 mg (milligrams) give one tablet by mouth daily for diagnosis of depression / anxiety. 7/18/14Nicotine (A patch to stop nicotine cravings) Patch 7 mg/24 hours apply to skin every day. Remove old patch before applying new patch for diagnosis smoking cessation. 7/18/14Brovana (A bronchodilater inhaler medication) 15 mcg (micrograms) | | | | |

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| | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|---------------|---------------------------------------|--|------------------|---|---------------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED |
| | | | B. WING | | 08/28/2014 |
| NAME OF E | PROVIDER OR SUPPLIER | • | STREET . | ADDRESS, CITY, STATE, ZIP CODE | - |
| | | | | TECHNOLOGY DR | |
| | POINTE OF CARMI | | | EL, IN 46032 | · · · · · · · · · · · · · · · · · · · |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | ` | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | <u> </u> | TAG | DEI CHERCI) | DATE |
| | ` | s) solution Inhale 15 mcg | | | |
| | two times a day | • | | | |
| | | rder changed on 7/29/14) | | | |
| | _ | 18 mcg Handihaler | | | |
| | device (A bronch | | | | |
| | · · · · · · · · · · · · · · · · · · · | ale contents of one | | | |
| | | V (Handihaler nebulizer) | | | |
| | , , , | sis of empysema. | | | |
| | 7/18/14Duonel | * | | | |
| | | nedication) 0.5-3 (2.5) | | | |
| | "" | via nebulizer two times | | | |
| | ' | sis empysema. (Order | | | |
| | changed on 7/29 | | | | |
| | 7/18/14Medica | tions may be started | | | |
| | when available f | rom Pharmacy. | | | |
| | 7/23/14Hold B | rovana Solution 15 mcg | | | |
| | twice a day until | available from | | | |
| | pharmacy. | | | | |
| | 7/29/14Brovan | a Solution use 1 vial via | | | |
| | nebulizer twice a | a day as needed for | | | |
| | shortness of brea | ıth. | | | |
| | 7/29/14Duonel | use one vial nebulizer | | | |
| | every six hours a | as needed for shortness of | | | |
| | breath. | | | | |
| | TL. MAD 1/ 1 | I 1 2014 :1: 1.1 | | | |
| | | July 2014, indicated the | | | |
| | ` | s initials were circled on | | | |
| | | tes for the following | | | |
| | medications: | | | | |
| | | 19/14 and 7/20/14 so the | | | |
| | | 2 doses of medication. | | | |
| | | 7/19/14 through 7/21/14 | | | |
| | so the resident m | nissed 3 doses of | | | |
| | medication | | | | |
| | • | | | • | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 28 of 42

| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING B. WING | | NSTRUCTION 00 | (X3) DATE COMPL 08/28 / | ETED |
|--------------------------|---|--|-----------------------------------|-------|--|--------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | STF 11 | 610 T | DDRESS, CITY, STATE, ZIP CODE ECHNOLOGY DR L, IN 46032 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TA | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| | Spiriva7/19/14 resident missed Brovana7/18/1 the medication v available on 7/28 missed 14 doses Duoneb7/18/14 resident missed The back of the indicated the fol 7/18/14 at 9 P.M zero] supply not 7/18/14 at 9 P.M zero] supply not 7/21/14 at 8 A.M supply Exhauste 7/21/14 at 8 A.M supply Exhauste 7/21/14 at 9 P.M zero] supply ND not given." 7/21/14 at 9 P.M zero] MD notifie 7/22/14 at 9 P.M zero] supply MD 7/22/14 at 9 P.M zero] supply MD 7/23/14 at 9 P.M | through 7/21/14 so the 3 doses of medication. 4 through 7/23/14 when was placed on hold until 8/14 so the resident of medication. 4 through 7/22/14 so the 10 doses of medication. MAR's dated July 2014, lowing: 1., "Duoneb [sign for given." 1., "Brovana [sign for given." 1., "Multivitamin p.o. d pharmacy notified." 1., "Spriva [sic] p.o. d pharmacy notified." 1., "Brovana [sign for notified / Pharm notified, "Duoneb [sign for ed." 1., "Brovana [sign for notified / Pharm notified, "Duoneb [sign for ontified." 1., "Brovana [sign for ontified." 1., "Brovana [sign for ontified." 1., "Duoneb [sign for ontified." 1., " | | | | | |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: | A. BUILDING B. WING | 00 | COMPLETED 08/28/2014 |
|--------------------------|--|--|----------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | | 11610 | ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | dated 7/23/14 at Brovana medicat Pharmacy called medication requi MD notified." A "Consolidated the Pharmacy dat that the resident's | nary Progress Note" 3 P.M., indicated "Res ion not available, Pharmacist stated that res a prior authorization. Delivery Sheet" from ted 7/21/14, indicated Multivitamin, Nicotine haler, and Sertraline | | | |
| | | e received from the s day at 8:30 P.M., by | | | |
| | the Pharmacy da that the resident's nebulizer treatme | Delivery Sheet" from ted 7/28/14, indicated s Brovana Solution for ents were received from this day at 8:30 P.M., by | | | |
| | A.M., the Nurse resident was adm on a Friday after did not deliver or and that was why her medications of She indicated ever facility had an or may be started w | dew on 8/28/14 at 10:30 Consultant indicated the nitted to the facility late moon and the Pharmacy in Saturdays and Sundays of the resident did not get delivered until 7/21/14. The resident in the der that medications hen they were available cy. She indicated the | | | |

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PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|---------------------|--------------------------------|-------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | |
| | | | B. WING | | 08/28/2014 | |
| N43 55 55 | DROLUBER OF STATE | <u> </u> | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF | PROVIDER OR SUPPLIE | К | | TECHNOLOGY DR | | |
| CROWN | IPOINTE OF CARM | 1EL | CARMI | EL, IN 46032 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | · · | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | | ought some medications | | | | |
| | | ne other facility she came | | | | |
| | | ust have exhausted her | | | | |
| | | licated the facility's back | | | | |
| | | t for emergency drugs | | | | |
| | only the residen | | | | | |
| | | m the (Name of | | | | |
| | | Nurse Consultant | | | | |
| | | cility did not have an | | | | |
| | , , | cy Drug Kit) because it | | | | |
| | | Living facility. The | | | | |
| | | nt indicated the resident | | | | |
| | needed a Prior | Authorization (PA) for the | | | | |
| | Brovan Solution | n and that was the reason | | | | |
| | she had not rece | eived it until 7/28/14. She | | | | |
| | | cility notified the | | | | |
| | Physician a PA | was needed, but the | | | | |
| | Pharmacy was i | responsible for obtaining | | | | |
| | the PA. | | | | | |
| | A current policy | y titled "Medications | | | | |
| | | Administration" undated, | | | | |
| | | Executive Director on | | | | |
| | 1 ^ | A.M., indicated "In the | | | | |
| | | ng ordered medications, | | | | |
| | _ | ation be out of supply or | | | | |
| | | administration, the | | | | |
| | | or QMA is responsible to | | | | |
| | | g:consider the | | | | |
| | | for the medication, either | | | | |
| | | nitiation of treatment | | | | |
| | | e of an antibiotic) or due | | | | |
| | | | | | | |
| | _ | a therapeutic blood level | | | | |
| | (e.g., in the case | e or anti-seizure | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 31 of 42

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COMPI 08/28 | LETED |
|--------------------------|--|---|--|---|----------------|----------------------------|
| | PROVIDER OR SUPPLIEF | | 11610 7 | ADDRESS, CITY, STATE, ZIP CODE FECHNOLOGY DR EL, IN 46032 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| | needed immedia if available, obta EDK for admini contact the pharmacy you are which will delay (for example, the been filled and i refilled; the medication as ignificant delay the medication as ignificant delay doses), we must notify him/her of ordered medication (white will able to the property of the medication as ignificant delay doses). | f the medication is tely, check the EDK and, ain the dose from the stration then proceed to macy for delivery of a contacting the re informed of a situation or complicate delivery e medication has recently the istoo soon for it to be dication is not "covered" ministrative nursing/DON over to proceed and to mave notified them that not (or will not) receive as ordered until further and is takenIf there will be any (e.g., 2-3 omitted contact the physician and of the unavailability of the ion to provide him/her unity to order an alternate check may be in the EDK or stations with deliveryfor | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 32 of 42

| | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | E CONSTRUCTION 00 | r / | E SURVEY |
|----------|---|---|---------------|---|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | | PLETED |
| | | | B. WING | | 08/2 | 28/2014 |
| | PROVIDER OR SUPPLIER | | 1161 | ET ADDRESS, CITY, STATE, ZIP COD 10 TECHNOLOGY DR MEL, IN 46032 | ÞΕ | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | DROVIDENG N. AN OF CORDEG | THOM: | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI | ILD BE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | TOTAL | DATE |
| R000305 | 410 IAC 16.2-5-6(Pharmaceutical Si (f) Residents may choice for medicar facility, as long as (1) complies with the packaging, and laid products unless call laws; (2) provides prescand timely basis; as (3) refills prescript order to prevent in regimens. Based on interviting the facility failed medications provided timely manner and disruption of the 8 residents reviewed in the facility failed medication delived (Resident #102 are Findings included 1. The record for reviewed on 8/20 Diagnoses included 1. The record for reviewed 1. | ervices - Noncompliance use the pharmacy of their tions administered by the the pharmacy: the facility policy receiving, beling of pharmaceutical contrary to state and federal eribed service on a prompt and ion drugs when needed, in atterruption of drug ew and record review, If to ensure that vided to residents in a and in order to prevent a air drug regimen for 2 of wed for timeliness of erry from the Pharmacy. and #413) Example 102 was 6/14 at 3:46 P.M. ded, but were not limited osteoarthritis, depression ive pulmonary disease reterial disease. Exation Administration agust 2014, included, but to the following | R000305 | 1.Resident #102 and #not harmed. The physiciaresponsible party were not resident #102 and # 413. Resident #102's prescript Morphine Sulfate was filled promptly when the hard so was received by the pharmact pharmacty and facility wouth the physician to obtain the authorization for the Brown solution. 2.All residents utilizing medications have the post be affected. All medication were checked with the madministration records to all ordered medications were re-educated on the procedure for medication unavailable for administration (please see attachment, 3.As a measure for one compliance the DON or compliance the DON or compliance the DON or compliance the procedure reserves the procedure of the procedure of the procedure for medication unavailable for administration the procedure for medication the procedure for medication the procedure for medication the procedure for medication the procedure | an and otified for otion for ed script macy as esident ins upon cy. The rked with the prior vana tential to on carts edication ensure edication ensure edication, D). going | 09/12/2014 |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 33 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---------------------------------------|---|-------------------|--------------|--|--------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A DIIII | LDING | 00 | COMPL | ETED |
| | | | A. BUII B. WIN | LDING | | 08/28/ | 2014 |
| | | | D. WIIN | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIEF | R | | | FECHNOLOGY DR | | |
| CROWN | POINTE OF CARM | FI | | | EL, IN 46032 | | |
| | | | _ | | 12, 11 10002 | | |
| (X4) ID PREFIX | | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | ΓE | DATE |
| | | iate narcotic pain | 1 | 1110 | will review MAR's weekly ongo | ina | Dille |
| | | mg (milligrams) give | | | to monitor for medication | 3 | |
| | · · · · · · · · · · · · · · · · · · · | | | | unavailability (please see | | |
| | | outh every 12 hours for | | | attachment I). Any medications | | |
| | diagnosis chroni | • | | | noted to be unavailable will be | | |
| | | Morphine sulfate ER 100 | | | addressed immediately to ensithe resident receives medication | | |
| | mg until it arrive | es from the Pharmacy. | | | in a timely manner in order to | J113 | |
| | | | | | prevent a disruption of their dr | ug | |
| | | August 2014, indicated | | | regimen. | | |
| | | 4 at 8 P.M. to 8/27/14 at | | | 4.As a measure of quality | | |
| | 8 A.M., all the n | urses and QMA's | | | assurance the DON will complete the above described monitoring | | |
| | (Qualified Medi | cation Aides) initials | | | ongoing. Should a deficient | 9 | |
| | were circled on t | the 8 A.M. and 8 P.M. | | | practice be observed, immedia | ite | |
| | boxes for the the | e Morphine Sulfate order | | | corrective action will be taken. | | |
| | for a total of 10 | doses of Morphine | | | The plan of correction will be | | |
| | Sulfate not admi | nistered. | | | revised accordingly, if warrante The Administrator/Director or | ed. | |
| | | | | | designee will monitor and sign | off | |
| | The back of the | MAR dated August | | | on the monitoring tools on a | OII | |
| | 2014, indicated: | | | | monthly basis ongoing. | | |
| | · · | I., "Morphine Sulf ER | | | | | |
| | 100 mg not avai | - | | | | | |
| | _ | 1., "morphine Sulf ER | | | | | |
| | 100 mg not avail | • | | | | | |
| | notified." | таоте риатинасу | | | | | |
| | | Morphine sulf ED 100 | | | | | |
| | | I., Morphine sulf ER 100 | | | | | |
| | | & pharmacy notified." | | | | | |
| | • | ine Sulf 100 mg supply | | | | | |
| | Exhausted pharm | | | | | | |
| | - | ine Sulf 100 mg supply | | | | | |
| | Exhausted pharm | macy notified." | | | | | |
| | | | | | | | |
| | • | inary Progress Note" | | | | | |
| | dated 8/25/14 at | 8 A.M., indicated | | | | | |
| | "Resident is out | of Morphine as of day 3. | | | | | |
| | Resident needs r | new script, pharmacy | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 34 of 42

| | OF CORRECTION IDENTIFICATION NUMBER: | A. BUILDING B. WING | 00 | COMPI 08/28 | LETED |
|--------------------------|---|----------------------|--|----------------|----------------------------|
| | PROVIDER OR SUPPLIER POINTE OF CARMEL | 11610 7 | ADDRESS, CITY, STATE, ZIP CODI FECHNOLOGY DR EL, IN 46032 | . | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| | notified, MD notified, D.O. N. notified, Family notified, Resident notified." | | | | |
| | An "Interdisciplinary Progress Note" dated 8/26/14 at 9 P.M., indicated "Resident out of Morphine MD aware pharmacy awaiting script hard copy before they can send per pharmacyc/o [complaints of] pain scheduled Norco administered" A "Consolidated Delivery Sheet" from the Pharmacy dated 8/27/14 at 8:30 P.M., indicated 60 Morphine Sulfate ER 100 mg tablets were accepted by LPN #3 from the Pharmacy delivery personnel. Resident #102 signed a form titled (Name of Pharmacy) "Pharmacy Consent Form" dated 7/12/13, that indicated she had initialed by a line that included, but was not limited to the following: "I acknowledge that I have been provided with a copy of the Pharmacy Service Permission Form." A document titled (Name of Pharmacy) "Pharmacy Services Permission Form" indicated, "The pharmacy services as provided in this facility have been explained to me and I wish to take advantage of this serviceI further understand that the pharmacy that I designate must provide sufficient services | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 35 of 42

PRINTED: 09/15/2014 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATE | ION NUMBER: | A. BUILDING 3. WING | 00 | COMPLETED 08/28/2014 |
|---|--|----------------------|---|----------------------|
| NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL | • | 11610 T | DDRESS, CITY, STATE, ZIP CODE ECHNOLOGY DR IL, IN 46032 | |
| (X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE P TAG REGULATORY OR LSC IDENTIFY | PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE |
| to adequately protect the sar patient and must properly so of the facilityAdditionally pharmacy must provide 24 lemergency prescription served 16.2-3-8 Sec.8). Such arrands to be made in writing from the pharmacyPlease designated pharmacy selection by initial choice on the Pharmacy Colorand signing the consent form. During an interview on 8/28 A.M., the Nurse Consultant circled medication on the Medication was not give indicated the resident's More 100 mg was not delivered unbecause the Pharmacy need script for the medication and Physician continued to fax to the Pharmacy. She indicated would communicate to the left the Pharmacy needed the second form the facility continued to the Pharmacy needed the second from the facility continued to the Pharmacy of the Physician he needed to the Physician he needed to the Physician he needed to the Pharmacy. 2. The record for Resident reviewed on 8/27/14 at 12:3 | erve the needs y, the hour vice (410 IAC ngements must e providing e your alizing your nsent Form m" 8/14 at 10:17 c indicated a MAR indicated en. She rphine Sulfate intil 8/27/14 ed a hard d the the script to ed the facility Physician that cript and he macy needed she indicated ommunicated to write a hard ility and the e tote to send #413 was | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 36 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY | | |
|--|--|---------------------------|------------|------------|--|------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLETED | |
| | | | B. WIN | G | | 08/28/2014 | |
| NAME OF I | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| WINE OF TROVIDER OR GOTTELER | | | | | ECHNOLOGY DR | | |
| CROWNPOINTE OF CARMEL | | | | CARME | EL, IN 46032 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES | | | | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | | TAG | DEFICIENCY) | DATE | |
| | _ | ded, but were not limited | | | | | |
| | * | lar accident, chronic | | | | | |
| | | , diabetes mellitus type | | | | | |
| | II, hypertension, | congestive heart failure, | | | | | |
| | vascular dement | ia, depression, and | | | | | |
| | osteoarthritis. | | | | | | |
| | A (MAD) Madia | nation Administration | | | | | |
| | ` ′ | cation Administration | | | | | |
| | | ly 2014, included, but | | | | | |
| | were not limited the following Physician orders: 7/18/14Multivitamin (A supplement | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | , , | e one tablet by mouth | | | | | |
| | | sis of supplement. | | | | | |
| | | ine HCL (Hydrochloride) | | | | | |
| | ` _ | ant medication) 50 mg | | | | | |
| | | e one tablet by mouth | | | | | |
| | daily for diagnos | sis of depression / | | | | | |
| | anxiety. | | | | | | |
| | 7/18/14Nicotir | ne (A patch to stop | | | | | |
| | nicotine craving | s) Patch 7 mg/24 hours | | | | | |
| | apply to skin eve | ery day. Remove old | | | | | |
| | patch before app | lying new patch for | | | | | |
| | diagnosis smoki | ng cessation. | | | | | |
| | 7/18/14Brovan | a (A bronchodilater | | | | | |
| | inhaler medicati | on) 15 mcg (micrograms) | | | | | |
| | / 2 ml (milliliters | s) solution Inhale 15 mcg | | | | | |
| | two times a day for diagnosis | | | | | | |
| | 1 | rder changed on 7/29/14) | | | | | |
| | 7/18/14Spiriva 18 mcg Handihaler | | | | | | |
| | device (A bronci | • | | | | | |
| | ` | ale contents of one | | | | | |
| | , , , , , , , , , , , , , , , , , , , | N (Handihaler nebulizer) | | | | | |
| | - | sis of empysema. | | | | | |
| daily for diagnosis of ompysonia. | | | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 37 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | (X3) DATE COMPI - 08/28 | LETED | | | |
|--|---|--|--|---|--------|----------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | | |
| | mg give one vial a day for diagno changed on 7/29 7/18/14Medica when available from 7/23/14Hold B twice a day until pharmacy. 7/29/14Brovan nebulizer twice a shortness of breat 7/29/14Duonel every six hours a breath. The MAR dated nurses or QMA's the following da medications: Multivitamin-7/resident missed 2 Nicotine Patchso the resident medication Spiriva7/19/14 resident missed 3 Brovana7/18/14 the medication vavailable on 7/28 missed 14 doses Duoneb7/18/14 | nedication) 0.5-3 (2.5) I via nebulizer two times as empysema. (Order /14) Itions may be started from Pharmacy. Irovana Solution 15 mcg available from a Solution use 1 vial via a day as needed for ath. It use one vial nebulizer as needed for shortness of July 2014, indicated the sinitials were circled on tes for the following 19/14 and 7/20/14 so the 2 doses of medication. 7/19/14 through 7/21/14 hissed 3 doses of through 7/21/14 so the 3 doses of medication. 4 through 7/23/14 when was placed on hold until 8/14 so the resident | | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 38 of 42

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO A. BUILDING | 00 | | COMPLETED | |
|---|---|---|---------------------|--|------------|----------------------|
| | | B. WING | | 08/2 | 08/28/2014 | |
| NAME OF PROVIDER OR SUPPLIER | | | 11610 7 | ADDRESS, CITY, STATE, ZIP C | CODE | |
| CROWNPOINTE OF CARMEL | | | | EL, IN 46032 | | _ |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| | indicated the fol 7/18/14 at 9 P.M zero] supply not 7/18/14 at 9 P.M zero] supply not 7/21/14 at 8 A.M supply Exhauste 7/21/14 at 8 A.M supply Exhauste 7/21/14 at 9 P.M zero] supply ND not given." 7/21/14 at 9 P.M zero] MD notifie 7/22/14 at 9 P.M zero] supply MD 7/22/14 at 9 P.M zero] supply MD 7/22/14 at 9 P.M zero] supply MD 7/23/14 at 9 P.M zero] supply MD 7/23/14 at 9 P.M zero] supply Me MD." 7/23/14 at 9 P.M zero] supply me MD. An "Interdisciplidated 7/23/14 at Brovana medica Pharmacy called | I., "Duoneb [sign for given." I., "Brovana [sign for given." I., "Multivitamin p.o. d pharmacy notified." I., "Spriva [sic] p.o. d pharmacy notified." I., "Brovana [sign for onotified / Pharm notified I., "Duoneb [sign for ed." I., "Brovana [sign for onotified." I., "Brovana [sign for onotified." I., "Duoneb [sign for onotified." I., "Duoneb [sign for onotified." | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 39 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | NSTRUCTION 00 | COM | TE SURVEY MPLETED 28/2014 | | | |
|--|--|------------------------------|--|---|---------------------------------|------------|--|--|
| | | | B. WING | | | 20/2014 | | |
| | PROVIDER OR SUPPLIEI | | STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032 | | | | | |
| (X4) ID | SUMMARYS | TATEMENT OF DEFICIENCIES | ID | | | (X5) | | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH | OULD BE | COMPLETION | | |
| TAG | G REGULATORY OR LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE AI DEFICIENCY) | PPROPRIATE | DATE | | |
| | A "Consolidated Delivery Sheet" from | | | | | | | |
| | | ated 7/21/14, indicated | | | | | | |
| | 1 | 's Multivitamin, Nicotine | | | | | | |
| | | nhaler, and Sertraline | | | | | | |
| | | re received from the | | | | | | |
| | | is day at 8:30 P.M. by | | | | | | |
| | LPN #3. | | | | | | | |
| | | | | | | | | |
| | A "Consolidated | l Delivery Sheet" from | | | | | | |
| | | ated 7/28/14, indicated | | | | | | |
| | 1 | 's Brovana Solution for | | | | | | |
| | | ents were received from | | | | | | |
| | the Pharmacy on this day at 8:30 P.M. by | | | | | | | |
| | LPN #3. | tuns day at 6.50 t .wr. by | | | | | | |
| | LIN #3. | | | | | | | |
| | Resident #413 s | igned a form titled (Name | | | | | | |
| | | Pharmacy Consent Form" | | | | | | |
| | 1 | nat indicated she had | | | | | | |
| | · · | e that included, but was | | | | | | |
| | not limited to th | • | | | | | | |
| | | at I have been provided | | | | | | |
| | _ | he Pharmacy Service | | | | | | |
| | Permission Form | | | | | | | |
| | 1 CHIIISSIOH FOIL | 11. | | | | | | |
| | A document title | ed (Name of Pharmacy) | | | | | | |
| | | rices Permission Form" | | | | | | |
| | 1 | pharmacy services as | | | | | | |
| | | facility have been | | | | | | |
| | _ | and I wish to take | | | | | | |
| | • | s serviceI further | | | | | | |
| | 1 | the pharmacy that I | | | | | | |
| | | provide sufficient services | | | | | | |
| | | otect the safety of the | | | | | | |
| | | t properly serve the needs | | | | | | |
| | panem and mus | i property serve the needs | 1 | | | | | |

State Form Event ID: YLBH11 Facility ID: 012309 If continuation sheet Page 40 of 42

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|---|--|---------|------------|---|--------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUIL | DING | 00 | COMPL | | |
| | | | B. WING | 3 <u> </u> | | 08/28/ | 2014 |
| NAME OF P | PROVIDER OR SUPPLIER | | _ | | ADDRESS, CITY, STATE, ZIP CODE | - | |
| | | | | | ECHNOLOGY DR | | |
| CROWNPOINTE OF CARMEL | | | | CARME | EL, IN 46032 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | of the facilityA | • / | | | | | |
| | pharmacy must p | | | | | | |
| | " " " | cription service (410 IAC Such arrangements must | | | | | |
| | | ng from the providing | | | | | |
| | | se designate your | | | | | |
| | | ion by initializing your | | | | | |
| | 1 ^ | armacy Consent Form | | | | | |
| | and signing the o | - | | | | | |
| | | OHSCH TOTHI | | | | | |
| | During an interv | iew on 8/28/14 at 10:30 | | | | | |
| | During an interview on 8/28/14 at 10:30 A.M., the Nurse Consultant indicated the | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | resident was admitted to the facility late on a Friday afternoon and the Pharmacy | | | | | | |
| | _ | nedications on Saturdays | | | | | |
| | | I that was why the | | | | | |
| | | get her medications | | | | | |
| | l ' | /21/14. She indicated | | | | | |
| | | the facility had an order | | | | | |
| | 1 | may be started when | | | | | |
| | | ble from the Pharmacy. | | | | | |
| | | e resident had brought | | | | | |
| | | ns with her from the other | | | | | |
| | | e from, but she must have | | | | | |
| | 1 | apply. She indicated the | | | | | |
| | | plan was that for | | | | | |
| | emergency drugs only the resident's could | | | | | | |
| | obtain medications from the (Name of | | | | | | |
| | Pharmacy -back-up). The Nurse | | | | | | |
| | Consultant indicated the resident needed | | | | | | |
| | a Prior Authoriza | ation (PA) for the Brovan | | | | | |
| | | t was the reason she had | | | | | |
| | not received it u | ntil 7/28/14. She | | | | | |
| | indicated the fac | ility notified the | | | | | |
| | i e | | 1 | I | | J | |

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| STATEMENT OF DEFICIENCIES X1) PROVI | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|---|--|------------------------------|----------------------------|----------|--|------------|--|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILI | NING | 00 | COMPL | ETED | | |
| | B. WING | | | 08/28/ | /2014 | | | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | | |
| NAME OF F | PROVIDER OR SUPPLIE | (| | 11610 T | ECHNOLOGY DR | | | |
| CROWNPOINTE OF CARMEL | | | CARMEL, IN 46032 | | | | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | | |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | DATE | | |
| | - | was needed, but the | | | | | | |
| | Pharmacy was r | esponsible for obtaining | | | | | | |
| | the PA. | | | | | | | |
| | | | | | | | | |
| | During an interview on 8/28/14 at 11:15 | | | | | | | |
| | A.M., the Executive Director indicated | | | | | | | |
| | each resident was able to choose what | | | | | | | |
| | Pharmacy they wanted to order their | | | | | | | |
| | medications from. He indicated both | | | | | | | |
| | | | | | | | | |
| | residents had requested (Name of the | | | | | | | |
| | Pharmacy) to fill their medications. He | | | | | | | |
| | | sidents sign an agreement | | | | | | |
| | with the Pharmacy to have their | | | | | | | |
| | medications filled. The facility did not | | | | | | | |
| | have a contract with the Pharmacy. | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

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